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ABSTRACT

This paper notes that therapists often feel unqualified to deal with special populations of children because of a lack of understanding of the universalness of play therapy. Suggestions are offered for beginning play therapists who may work with a number of special populations of children. It is recommended that the social learning approach to play therapy be used when working with children who have a gender identity disorder, defined as distress about one's assigned sex and the desire to be (or insistence that one is) the opposite sex. A section on working with culturally different children considers how people are defined within different cultures and notes that, with minority children, a more structured approach to play therapy is advised. For therapists working with physically challenged children, it is suggested that the therapist accept and not protect the child from feelings of rage, anger, disappointment, and depression. The importance of allowing the child as much independence as safety permits is emphasized. Suggestions are made for adapting toys or creative arts materials for use with intellectually challenged children. Games, techniques, and materials appropriate for challenged children are described and their use is discussed. The final section of the paper deals with play therapy techniques that are appropriate for use with chronically ill, terminally ill, and grieved children. (NB)

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PLAY THERAPY WITH SPECIAL POPULATIONS

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Abstract

A presentation given at The University of Alabama for beginning play therapists on working with special populations of children. Included are information on working with severely ill, physically and intellectually challenged, and cross-gender identification disordered.

PLAY THERAPY WITH SPECIAL POPULATIONS

Therapists often feel unqualified to deal with special populations of children, because of a lack of understanding the universalness of play therapy. Play therapy has been shown to be applicable to one of the broadest of applications and theoretical bases. Special interest has been in play therapy with cross-gender identified, culturally different, physically challenged, intellectually challenged, chronically ill, terminally ill, and children in grief. While a comprehensive discussion of each of these populations is beyond the scope of a single paper, the following are indicators or starting places for the beginning play therapists.

CROSS-GENDER IDENTIFIED CHILDREN (Rekers, 1981)

Gender identity disorder is defined, "persistent and intense distress in a child about his or her assigned sex and the desire to be-or insistence that one is- the opposite sex. This feature does not imply mere sex role

nonconformity, but rather a profound disturbance of the sense of maleness or femaleness. Boys with this disorder are either preoccupied with stereotypic female activities or persistently repudiate their male anatomy. In girls, there is persistent, marked aversion to normal feminine clothing or repudiation of female anatomical characteristics. The diagnosis is not made after the onset of puberty" (Reid & Wise, 1989, p.62). Reid and Wise (1989) state that the predisposing factors include "effeminate physical features in boys, subtle or obvious reinforcement of opposite-sex behavior, unduly weak reinforcement of normal gender-role behavior, nonavailability of a father, physical and psychological seductiveness by the mother" (p.62). The treatment of this disorder is critical because the child is placed at a high risk of developing psychological problems (Rekers, 1983).

According to Rekers (1983), biological factors may contribute; but primarily, social learning appears to be the primary factor. Therefore, the social-learning approach to play therapy has been found to be most successful in working with this special population. The

basic approach consists of separating the toys and costumes into male and female groupings. The child is ignored when approaching an inappropriate sex identified toy. Attention and conversation are provided when the child is playing with a sex appropriate toy in a sexually appropriate manner.

In addition to the therapists conducting sessions in this manner, the parents are also instructed in maintaining the same regime in their home. The parents were first provided controlled training with the bug-in-the-ear technique. They were told to ignore inappropriate behavior by holding a magazine up in front of their faces (Rekers, 1983).

A self-monitoring system was used with one child. Rekers (1983) provided the child with a wrist counter. The child could only "score" when he was playing with masculine toys. The therapist designated each toy as masculine or feminine. This method was also used in the home by the parents.

While play behaviors and sex-typed speech seem to respond well to extinction techniques, cross-gender mannerisms were found to respond to token economies.

Rekers (1983) gave the child a group of tokens at the beginning of the play session. Each time an opposite gender mannerism was observed, the child forfeited a token.

In the case of athletic participation, the therapist provided training for athletic skills. The child was simply taught the basic skills for sports that he/she did not have (Rekers, 1983).

While this may appear to solve many problems that are presented in the clinical situation, it must be remembered that this area of intervention is highly controversial. With the current atmosphere of civil rights being extended to sexual orientation, a therapist doing this type of therapy could easily result in being sued for violation of civil rights. There is currently some research to indicate that changing the sexual orientation of a child may lead to transsexualism. In addition, it is the opinion of the author that sexual orientation cannot be changed, rather that a therapist can only provide a child with the social skills to be accepted, if the child appears to be concerned about peer acceptance. At any risk, the child should not be made to

feel unworthy or guilty about his or her sexual orientation.

CULTURALLY DIFFERENT CHILDREN (Carmichael, 1991; Triandis, 1987)

Cultures differ along the following lines: what people do; who people are; in-group; out group; trust; age; gender; religion; language; race; tribe/extended family; status; meta communication versus content; self-concept versus people identity; customs; and individualist versus collectivist (Triandis, 1987). To understand the play of a child, one needs to observe how each of these plays a role in the play themes. Understanding the traditional attitudes and customs of a particular group, sect, or race of people is helpful. However, a therapist needs to establish how traditional the child and the child's family of origin are. Families and children are acculturated at different levels; therefore **all** people, even in the same family, may not share the same views or cultural milieu.

Triandis (1987) focuses on the issue that cultures define people according to two elements: what people do

or who people are. His example is that of the spanking of a child. If the focus is on what people do, then the observer from the culture may be horrified that one person is striking another. If the cultural emphasis is on who people are, then the observer will say that a mother has a "right" to spank her child. While minorities in the United States tend to be more in tune to who people are, communities differ in their orientation of the emphasis and the acculturation to the community will differ with individuals.

In every group of people whether the group is based on family, race, community, ethnicity or other distinction, there are in-groups and out-groups. The in-groups are those that are seen as "Most like us." The out-group are those that are seen as "most different from us." The continuum of in-group to out-group defines the prejudices of each group.

Cultures differ in their perception of who and how to trust others. Many cultures do not trust anyone outside the family, below a certain maturity, or of specific racial origin. Trust is something that is won. An easy way to find out what it takes is to ask the

client, "How do you know you can trust someone?" In children, earning their trust is experiential. The therapist behaves in a consistent and accepting way to the child, and the child will trust. Trust is sacred to all cultures.

Age and gender are systematic beliefs in all cultures. The popular cry of the seventies was "don't trust anyone over the age of thirty." Age can be considered as wisdom or as "out of step." One gender can be considered superior to another. Being male is often considered a superior position; but in some cultures, females dominate. In the United States the African American and Jewish cultures tend to be matriarchs. European cultures tend to be patriarchs. Eastern cultures tend to be age dominated. Mid-eastern cultures are usually male dominated societies.

Religion may define a culture. The Muslims, Christians, Buddhists and Jews throughout the world have cultures that may mediate the culture of the community or other differences. One of the problems that has plagued the Catholic church in North and South America is the blending of local spiritual beliefs with traditional

beliefs of the Church. While they share a common belief system, each community may have special practices from their previous religion. Unique practices in one area may be common place in another such as: speaking in tongues, possession of demons, taking up the serpent, being slain in the spirit, dark sided saints, foot washing, and encouragement of disassociation.

Chomsky (1972) maintains that we cannot express that which we do not have words to express. In other words, our cultural "feeling" is defined by the words of our language to express those feelings. Some languages do not have words to describe shadings of feelings or experiences. The child is perceived to have a limited realm of feelings, because of a lack of vocabulary. Jargon is also a method to keep the in-group in and the out-group out. If a child uses jargon, tell the child," I don't know what that means." Two reasons exist for not using the child's jargon: 1) using the jargon would be an intrusion by the therapist and 2) jargon meaning are unique to the person using it.

Racial issues are usually based on physical differences that cannot be changed. The important thing

for the therapist to remember is that because a person has a particular racial appearance does not mean that the person is culturally different. Race is a poor indicator of culture difference.

When children come from a traditional tribal background, as do Native Americans and many Southeastern Asians, the children are more responsive in groups. These tribal groups see the individual's problems as group problems. In cultures having extended families, it may be necessary to see grandparents, aunts, uncles, or other members outside the nuclear family. The primary care givers are not always the biological parents. Although a child may be from a traditional extended family or tribe, the child may be acculturated to a different norm.

Who is given status and how they are given status varies from culture. Status may be based on age, gender, or earned status. Many traditional Asians may take what a teacher, therapist or doctor says without question because of the status afforded to such people in their culture. Another culture may ignore any suggestions from a female, as women have no status in their culture.

Meta communication is the tone or intention behind the content of a statement. Some children who may not have limited language skills or who are bilingual will focus on the tone of the therapist not what is said. What is confusing about sarcasm is that there is an incongruent message between the meta communication and the content of the statement. The same incongruity leads many culturally different people to miss humor in satire. The therapist needs to be aware that the communication needs to be congruent, because the child may focus on one aspect of language more than another.

Self-concept is a particularly Western European ideal. The self-concept has to do with the related theme of cultures of individualism. Cultures focusing on self-concept and individualism will look at what is good for the individual. Cultures that have a people's identity or collectivist orientation will not be concerned about the individual, but what is beat for the whole. Western cultures tend to be self-concept/individualist orientated, while Eastern/South American cultures tend to be collectivist/people identity orientated.

Customs present the final element that differentiate

cultures. Customs and their adherence vary from family to family, individual to individual, and community to community. The best way to discover customs is to ask how people celebrate events in their lives. Most people will gladly share their customs or traditions, if the seeker appears sincere.

Play therapy in a nondirective manner is not usually successful with minority children. A more structured approach is advised. Carmichael (1991) found that children need to have items included in the playroom or toy selection that are culturally specific when possible. In addition, children may not be acculturated to the lack of structure in nondirective play therapy and may do much better with the structure of art work to begin (Carmichael, 1991).

PHYSICALLY AND INTELLECTUALLY CHALLENGED

Salomon (1983) found that play therapy was appropriate for the physically challenged. These children may be in greater need of unconditional positive regard and permissive attitudes than other children, according to Salomon (1983). Physically challenged

children need a therapist who will accept and not protect them from feelings of rage, anger, disappointment and depression. While these children may be more passive, initiate less, explore less, and act dependently, the therapist's role is to allow the child as much independence as safety will allow.

Li (1983) states that it would be naive to use play therapy with intellectually challenged children without adaptations. Characteristics associated with intellectually challenged children need to be considered. These characteristics are: personal vulnerabilities, cognitive-developmental limitations, and feelings of inadequacies. Li (1983) believes that the intellectually challenged child's personality is fragile and vulnerable with a tendency to over-react to minimal stresses. The intellectually challenged lacks language development and ability of abstract thinking (Li, 1983). The child will behave in a manner much below age mates.

Toys or creative arts materials may have to have special adaptations. Musselwhite (1986) offers the following suggestions:

1. Stabilize toys, like doll houses, to steady

surfaces with C-clamps.

2. Enlarge pieces of puzzles or cut them from stronger, easier to handle materials.
3. Affix parts to toys or art supplies that are hard to hold. Examples: foam hair curlers to brushes, velcro glove to hold items, magnetic glove or items on a mental tray, add large plastic buttons to on/off switches, etc.
4. Reduce the response by reducing the range of motion, for example: place dolls on elevated trays, cars on a tray or track.
5. Remove extraneous cues from toys so that they are seen away from a "busy" background.
6. Add or enhance cues with visual or tactile stimuli.
7. Improve safety by taping corners, plastic coatings, or reinforcing with sturdier materials.
8. Suspend toys that can be placed over a bed.

Salomon (1983) suggests that children who may not be able to grasp objects have paint brushes taped to hands or elbows to paint in play therapy. Dress up items

should be chosen with the handicapped child in mind. Items such as purses, hats, and scarves are easier for disabled children to manipulate. Bean bags may be preferred over balls for throwing, as they will not roll away from the child's reach (Salomon, 1983). Bradley (1970) suggests that the toy selection be limited and introduced one item at a time to children who do not have the requisite skills to play or who have difficulty exploring their environment, i.e., visually disabled, motor disabled.

Li (1983) suggests that intellectually challenged children use unstructured materials initially. The unstructured materials allow the child more control, creativity and development of play activity.

Irwin and McWilliams (1974) used creative dramatics with challenged children. The children attended two hour sessions each week. The first weeks focused on a "training period" in which the children participated in rhythmic activities, pantomime and guided dramatic play. A second period of preparation was having the children perform stories, and nursery rhymes already familiar to them. The final phase consisted of the children's

verbalized fantasies, original stories and expressions of fear. Puppets and simple costumes were provided. These children had to be hospitalized more often than nonchallenged children (Irwin & McWilliams, 1974). Hospital play, especially focusing on surgery, was a common theme. Where a therapist is working with a single child, toys can be "stand ins" for the necessary characters in the dramatic play.

Gardner (1974;1975) has proposed a mutual story telling method. The child tells a story. The therapist retells a variation on the child's theme in which negative behaviors or emotions are replaced with positive elements. Presently, a story telling game is available with movable tag board people and scenery to aid the therapist in the mutual story telling process.

The Talking, Feeling, and Doing Game (Gardner, 1975) is a board game with a curved three color path from start to finish. Each color corresponds with a specific deck of cards: talking, feeling, or doing. The child rolls the dice and moves ahead on the path. The color of the square the child moves to determines which type of card the child will draw. The cards have activities or

questions written on them. The activities are aimed at helping the child self-explore his/her feelings, expressions, and behaviors.

The Bag of Toys Game, The Bag of Things Game and The Bag of Words Game (Gardner, 1975) The bag of toys has a selection of 40 to 50 clearly recognizable miniatures of fantasy characters, real people, and environmental objects known to children, i.e., trucks, car, child, doll bottle, telephone. The Bag of things has 40 to 50 objects that are not clearly recognizable, i.e., a rock, lump of clay, a plastic ring, shells, monsters, plastic worms. The bag of words contains about 400 words, e.g., mother, father, girl, boy, anger, doctor, foolish, hate, love. The child reaches in and draws out an object or word. The child must then tell a story with the object or word drawn.

Intensive play (Bradtke, Kirkpatrick & Rosenblatt, 1972) is recommended for children who are blind, braced, deaf, palsied, dwarfed, retarded, nonverbal, epileptic, emotionally impaired and paralyzed. The purposes of intensive play are: to build awareness of self, others and environment; to reduce fear of physical contact; and

to help the unresponsive child become responsive. The children are paired with an adult for a thirty minute session. A specific hierarchy of activities is used, progressing from least threatening to most threatening. The first step in the hierarchy is to pat the child's body in rhythm. The progression of 30 activities ends with the adult standing, holding the child firmly by the ankles, and moving the child up and down so that hand s and head touch the floor. When the child has completed the activities with one adult, another adult is introduced. Once the responses are positive and consistent with the adults, child-to-child activities are initialed. These child-to-child activities are structured and supervised by adults (Bradtke, et al, 1972). Similar programs were described by Kraft (1983).

Kraft (1983) included a broader range of activities that dealt with rhythms, body awareness, gross-motor skills, fine motor skills, eye-hand, eye-foot coordination, and swimming. Activities included finger snapping, body alphabet contortions, trampoline stunts, clay sculpturing, finger painting, ring toss and blowing up balloons. Sessions were short with a one-on-one

relationship with the therapist.

Lambie (1975) describes the "toy library" approach. A diagnostic interview is conducted with he other family members present. During the session, the therapist demonstrates the therapeutic toys. The toys are presented one toy at a time. Each centers on a specific skill the child needs to accomplish. The toy may be "checked out," as one would a book from the library, for use in the home. When the skill represented by the toy is mastered, the parents and child are provided a new toy and instructions about its use.

Kraft (1981) used a group therapy setting pairing hearing with hearing impaired children. The hearing partner was used to reinforce directions and to provide a model of the skill. A trust exercise described by Kraft (1981) was "Car and Driver." One participant is a car; and the other is the driver. The drivers place their hand on the shoulders of the cars and direct the blindfolded car around the room. The partners reverse roles, so each can have the experience. Other suggestions include mirroring activities, mime stories, circle games, relay races, and balancing games (Kraft,

1981).

Marlowe (1979) described a "softball type" of game for use with physically challenged children. Softball was adapted by using a lighter, larger bat and a larger, softer ball. Rules were changed to accommodate the disabilities of the children. Other play programs have taken camping experiences, team sports, and physical education activities and adapted them to the special requirements of the child's disability (Roswal, 1983; Roswal, et al, 1984). The ratio of therapists to children is one-to-one.

Directive play therapy has not been shown to be more effective than nondirective play therapy with this population. Adaptations in nondirective play sessions may determine that the therapist be more active with disabled children than with children without disabilities. The therapist may have to hand toys to the child. The child may require assistance in arranging the toys or to move about the room. Setting limits about what a child may or may not do in the play room may have to be expanded to protect the child from physical injury (Salomon, 1983).

CHRONICALLY ILL, TERMINALLY ILL AND GRIEVED CHILDREN

Therapists are especially needed while a seriously ill child is dying or being confined. The therapist provides the support that the grieving family often cannot supply to the child. The child is more open to the outsider to disclose his or her deepest emotions without the therapist being "upset" like the parents or significant others. According to Allan and Bertoia (1988), even the beginning therapist can set up opportunities for symbolic release of these deep feelings that may escape the vocabulary development of the child.

Kubler-Ross (1983) found that children experience the same stages of grief that adults do. These stages are: denial, anger, bargaining, depression, and acceptance. Acceptance occurs when the child has come to gripes with the inevitable and makes the most of the time left. Kubler-Ross (1983) found that children could express their fears, hopes, and sorrow through creative arts, written or artistic. Given that some children may not be able to write or draw, the therapist may consider the voice activated tape recorder for the child's efforts or serving as a "secretary" for the child's dictation.

Children are found to move through five stages of self-concept, according to Bluebond-Langner (1978). These stages are: seriously ill, seriously ill and will get better, always ill and will get better, and dying. This sequence constant in that the child does not skip or accept knowledge until the stages completion. Allan and Bertoia (1988) state: "If the counselor can be aware of the process and allow the emotions experienced to be vented in drawings with understanding and acceptance and without judgment, the child can progress and can experience some sense of resolution and acceptance" (p. 207).

Children are encouraged to "draw something from one of your dreams," if they do not spontaneous draw. Some children may need guided imagery before drawing. Whatever method seems to work for the child, a broad selection of media should be available. Different paper textures and sizes, oil pastels, crayons, felt tip markers of varying sizes, pencil crayons, charcoal, sepia, and different lead hardness of pencil.

After the child has decided the picture is complete, the therapist thanks the child, acknowledges the effort,

dates it, and asks if there is a title. The child is encouraged to dictate or record a story about the picture, if there is one. The child is encouraged to talk about the drawing, if the child shows an interest in doing so. The picture is then added to a special file folder with other pictures the child has completed.

For interpreting the art work, Allan and Bertoia (1988) have these suggestions:

1. How do I feel about this picture? What emotions is the child expressing?
2. What is missing from this picture?
3. What is odd or stands out in this picture?
4. What colors are used and what colors are left out?
5. What is the placement on the page? How do the foreground and background relate to the child's life?

The family may find the pictures as a bridge to communicate with the child. Through the drawings, the family can see the stage of acceptance the child is in and shares his or her peace. If the child does not resolve the situation, the family still have the treasure

of the child's art work.

While Allan and Bertoia (1988) have discussed art work of children, the same type of analogies may be experienced through music, poetry, and prose developed by the child. Children do not have to be terminally ill to go through the grief process. The same process is experienced through divorce, death of significant other, moving, death of a pet, and loss of physical abilities. The same methods are used to become "inscapes" into the child's world.

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